(interrupted).

Q Okay. Since 1980, more than 100?

A Roughly I can say, but I cannot give the exact figure.

Q I'm sorry?

A I say I cannot give the exact figure. I don't know.

Q It's okay. I'm not asking for an exact. I'm asking for approximate.

A Approximately maybe say 100.

Q Since 1980?

A Or maybe more. I don't know. I cannot remember the exact number.

Q Okay. Again, I'm not asking ---

(interrupted).

A I understand, but I don't know the exact number. I cannot say that.

Q You said that. How about the approximate number?

BY MR. PEEPLES:

Objection to form; asked and answered.

BY THE WITNESS:

A I don't know the number approximately.

BY MR. BROOKS:

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(Whereupon, there was a brief recess taken.)

BY MR. BROOKS:

Q Doctor, earlier on you agreed that assessment of danger is essentially a risk assessment, did you not?

A Can you repeat the question?

Q Earlier on you acknowledged that an assessment of danger is essentially an assessment of risk.

A That's correct.

Q So, you would agree that you're looking at how likely this person is to cause harm to self or others when you are assessing for dangerousness?

A That's correct.

Q Okay. Now, when you're assessing a mentally ill person to determine whether he meets the criteria for involuntary hospitalization, would you agree that if there is a small chance that this person can cause harm to self or others, then that makes him dangerous?

A I don't know.

BY MR. BROOKS:

Q I tell you what, Doctor, from now on, and maybe it's my fault that I wasn't clear, if you don't understand the question, tell me you don't understand and I'll rephrase it. In fact, I'll say it's my fault for not making it clear. Okay? I apologize.

Doctor, is it your practice to carefully complete the two physician certificates?

A Yes. We have to -- yeah, we clinically interview the patient and we have to make a decision at times.

Q Are you diligent when you -- as a general rule, are you diligent when you complete the forms?

A After talking to patient, after interviewing the patient.

Q Yes.

A After collecting information from outside, then we make a -- after we interview the patient and before we reach the conclusion, we have to -- we have to decide whether the

patient can be dangerous to self or others.

Q I understand that.

A Yeah.

Q But then would you agree that you have to write down why you believe the person is dangerous?

A We do not write down everything in the piece of paper.

Q Do you write down the most important stuff?

A Usually we try to as much we can.

Q Is it a general practice for you to try and write down the most pertinent reasons why you believe the person is dangerous?

A Whatever information we got from other places and whatever information we have from the history, whatever was given to us, okay, when we check the records, and we see the admission screening note, and on that conclusion and after talking to patient, we correlate everything and then we make a decision, though we do not document everything on the piece of paper.

Q Maybe you don't document everything, but is it a general practice for you to document

the most important material?

A We try as much we can.

Q I'm not asking about the other people. I'm asking about you.

A I understand that.

Q Do you try to document the most important material relating to the assessment of dangerousness?

A We do not document everything on that piece of paper.

Q I'm not asking about everything.

A Yeah.

Q You told me that.

A Yeah.

Q I'm asking you as a general practice do you try to document the most important material relating to dangerousness?

A Like -- we try.

Q I'm not asking about others. I'm asking about you.

A Yeah.

Q Is it your general practice ---

(interrupted).

A Yeah.

Q -- to try to write down the most important material relating to dangerousness; yes or no?

A Yes.

Q And would you agree that it's important to write down the most important material relating to dangerousness?

A Yes.

Q And would you agree that one of the reasons why it is important to do so is because other clinicians are going to look at what you write and base their own decisions upon your clinical findings?

A Can you rephrase the sentence?

Q Would you agree that it's important to write down the most important material about dangerousness because other clinicians may well look at the record and base their own clinical decisions upon your clinical findings?

A That's right.

Q I'm sorry?

A That's correct.

Q Doctor, since you've been evaluating

go.

Q Well, what I'm asking you is can you recall, do you have a specific recollection, where you concluded the person was mentally ill, needed hospitalization, but was not dangerous, and you said, I want this person in the hospital, but I have to let him go and I will let him go? Can you recall that happening?

A I cannot recall right now. I don't know.

Q I'm sorry?

A I cannot recall.

Q Now, Doctor, would you agree that a person may pose a danger to others because he poses a risk of assaulting a person or otherwise causing intentional physical harm; agree or disagree?

A Agree.

Q Would you agree that another way a person poses a danger is that he poses a danger to himself because of a risk that he may attempt suicide or otherwise engage in self injurious behavior?

A Yes.

A Yeah.

Q Okay. Any others?

A I don't remember any more. I don't know any more.

Q Now, Doctor, I'd like to focus on the third category of danger; inability to meet needs, okay? When assessing whether or not someone is a danger to himself because of an inability to meet needs, is it important to look at whether or not the person suffered from malnutrition during the last period of time that he was living on an unconfined basis?

BY MR. PEEPLES:

Objection to form.

BY MR. BROOKS:

What's wrong with the form?

BY MR. PEEPLES:

What do you mean unconfined?

BY MR. BROOKS:

Not arrested, in jail, in a psychiatric hospital, anyplace.

Q Is it important to know whether or not the person suffered from malnutrition?

A It is important to know whether the patient suffered from malnutrition. That's part of the examination though.

Q Is it important to know whether or not the patient suffered from dehydration?

A That's very important, too.

Q Is it important to know whether or not the person suffered from any other physical infirmities that went untreated?

A Yes, it's important.

Q Is it important to know whether or not the person has a willingness to accept treatment?

A Yes.

Q Is it important to know whether or not the person has a willingness to accept treatment on an outpatient basis?

A Yes.

Q Is it important to know whether or not the patient has family members who are willing and able to provide support?

A Yes.

Q Is it important to know whether or not the person has an ability to listen to others

history whether they got hurt by walking in traffic or not, whether they are using any substance, alcohol or not.

Q Anything else?

A Any information we collect from the community what happens.

Q Such as?

A Such as in the past, like whether there is a similar episode in the past, what happened, how that happens.

Q Anything else?

A That's all I remember.

Q Fair enough. Now let's look at whether or not a person is a danger to others as a result of assaultive behavior. What factors do you look at?

A We look at the history first, what happens, whether they had similar incidents before or not.

Q History of prior assaultive behavior?

A Right, assaultive behavior.

Q What else?

A And whether this assaultive behavior was related to the delusion, like paranoid

times.

Q And?

A And whether they are taking their medication or not, whether they are using a substance or alcohol or not, and whether they have a family history positive or not, and that's the only think I remember right now.

Q How about the role of stressors?

A That's important, too.

Q Community support?

A It is also important, too.

Q Would you agree that if a person -- question withdrawn.

Would you agree that some hallucination make a patient more dangerous than other hallucinations?

A That's correct.

Q And wouldn't you agree that command hallucinations render a person far more dangerous than other hallucinations which may not be harmful in nature at all?

A Correct.

Q And would you agree that when looking at a person who suffers from delusions poses an

increased risk of harm, you have to know whether or not the person has ever acted on delusions in the past?

A It's important.

Q I'm sorry?

A Yes, it's important.

Q And would you also have to know the nature of the particular delusions of which the person suffers from?

A Yes.

Q Would you agree further that some delusions are far more risk enhancing than other delusions?

A Yes.

Q And would you degree whether or not a person intends to act on the delusions is important to know when assessing a person's dangerousness?

A Yes.

Q Would you agree further that a person who intends to act on delusions poses a far greater risk of harm than a person who does not intend to act on his delusions?

A Yes.

Q Would you agree that because a person who intends to act on his delusions poses a far greater risk of harm than does a person who does not intend to act on delusions, when assessing whether or not a delusional person is dangerous, a doctor should find out whether or not the person intends to act on the delusions?

A Can you just rephrase it? That's too long. I lost some of it.

Q Sure. About two minutes ago --- (interrupted).

A Okay.

Q -- you said a person who intends to act on delusions --- (interrupted).

A Yes.

Q -- poses a far greater risk of causing harm than does a person who does not intend to act on the delusions, correct?

A That's correct.

Q Would you agree that because of that, a clinician who attempts to determine whether or not a delusional person is dangerous should attempt to determine whether or not

A Criminal history.
Q Yes. Is that correct?
A Yes.
Q Would you agree further that if you know the person's involvement with criminal history, that even if the person does not have a history of assaultive behavior within the criminal justice system, the person's involvement or lack of involvement may provide pertinent information regarding the threat of harm he may pose?
A All information would depends on how -- whether they are involved with substance abuse, drug or alcohol involvement.
Q Involved with the criminal justice system?
A Right, yeah.
Q Now, Doctor, is it true that as a physician in an Office of Mental Health facility, you have access to a person's involvement in the criminal justice system?
A Nowadays we do have.
Q And when did you get this?
A It doesn't come right away day of admission but within two or three days we get a closer

Q Well, do you make an attempt to get this information --- (interrupted).

A Yes, information.

Q -- prior to completing the two PC certificate?

A That's correct.

Q How do you go about gathering this information?

A On the emergency room, where patient was brought, how was brought, from the family which is involved and also by looking at all the records.

Q I'm talking about the history with the criminal justice system that's on the computer. Is it your practice to attempt to gather this information prior to completing the two PC certificate?

A We check the records, like criminal history, if available. Sometimes it's not available at the time of conversion, but prior to that we would have whatever information available from the emergency room or whether patient came from the jail, we have some information, why he was committed in jail,

what crime he did. So, we try to get information as best we can.

Q Now, a second ago you said the information is not available prior to conversion. Is that what you said?

A Some information --- (interrupted).

Q But the word you said was conversion; is that correct?

A Yes, I did.

Q When you say conversion, do you mean a determination of whether or not the person is going to be converted to two PC status?

A That's correct.

Q And by being converted to two PC status, do you mean being certified for involuntary hospitalization under the Mental Hygiene Law?

A Can you just reframe it for me?

Q When you say converted to two PC status, do you mean being civilly committed?

A Yes.

Q Under the Mental Hygiene Law?

A Yes.

Q Now, you said this -- this information is

information yourself?

A From the patient, yes.

Q No, from the computer.

A No.

Q Why not?

A We didn't do that. That's usually -- I don't know. I didn't do it.

Q Ever?

A No.

Q My question is why not.

A That's a good question, but I didn't do it.

Q Let's talk about being a danger to self because of suicide and other self injurious behavior. What are the factors that relate to this type of dangerousness?

A What are the factors related to this --- (interrupted).

Q This type of danger.

A We check the past history first.

Q You're saying history of --- (interrupted).

A Yeah.

Q -- past suicide attempts?

A Past suicide attempts, right.

Q Okay. What else?

A We check the family history. We check the reason for why that happened, what was stress, any stress factors was involved, and whether this happened due to response to any specific delusions.

Q How about hallucinations, too?

A Yes, and equally drug and alcohol.

Q How about impulsivity?

A Yes.

Q How about the lack of future plans?

A It's important.

Q How about hopelessness?

A It's very important.

Q An intent to die or signals of intent to die?

A If somebody single, it's possibly they are more dangerously. Marital status, if somebody single, they're not married.

Q Oh, that's something else.

A That's okay.

Q No, because --- (interrupted).

A I'm sorry.

Q No, no. That's fine, because you misunderstood me, but we'll go to where

you're going, fine.

A Okay.

Q You're talking about single, separated, or divorced status; is that important?

A Yes.

Q So a person's marital status is important?

A That's correct.

Q Now, I'm not talking about marital status now, but whether or not the person has presented with some sort of signal that they intend to die.

A Yeah, that's very important.

Q Anything else?

A Recently broke up with a relationship.

Q Would you agree that having broken up in a relationship is enough of an indicia of danger as to warrant the finding of involuntary hospitalization because of dangerousness?

BY MR. PEEPLES:

Objection to the form.

BY THE WITNESS:

A You're trying to say the question that if somebody is dangerous because they broke off

a relationship --- (interrupted).

BY MR. BROOKS:

Q Yes.

A And ask for involuntary admission?

Q Yes.

A We may assess the patient and at that time we decide whether he meets criteria for admission as a voluntary status or not.

Q Involuntary you said, right?

A Involuntary or voluntary status.

Q Right. Any other factors?

A We have the support system, how many they have.

Q Anything else?

A Employment, whether they work or not.

Q I'm sorry?

A Whether they are working or not working, that's important.

Q Anything else?

A I don't remember anything right now.

Q All right. Now let's look at someone being a danger because of the use of drugs?

A Use of?

Q Use of drugs and alcohol.

Q In what way can someone pose a danger to themselves through use of drugs and alcohol that is different than what we've discussed previously?

A Then I don't know.

Q I'm sorry?

A I don't know.

Q Okay. Doctor, has anybody ever talked to you about how you assess dangerousness?

A We have lectures. We have conferences.

Q No, but has anybody evaluated the work you've done? And when I say the work you've done, the commitment forms you've completed and things of that nature. Has anybody ever evaluated the work you've done and spoken to you about how you conduct dangerousness assessments?

A Except education lecture, nobody tell us how to assess. That we learn by seeing, being at whatever lectures we have.

Q Well, when you go to a lecture, you sit down and you're provided information, correct?

A Yes.

Q And then you have to apply the information

that you've learned and gathered at these lectures, correct?

A Correct.

Q Has anybody ever sat down with you and evaluated your work and has spoken to you about how you've applied the information that you've learned?

A Nobody tell us how to do that, but that's we learn.

Q Has anybody ever told you you must attend particular lectures regarding dangerousness?

A Yes. We usually we -- they encourage us to attend the lectures for like anything, like how to assess suicidal behavior.

Q I'm sorry?

A They encourage you to attend the conferences whenever you're able to.

Q Is it mandatory?

A It's similar to mandatory. They ask you to attend as much you can, unless something, an emergency, comes up with a patient, then you cannot, but usually everybody attend that lecture, which is important to us.

BY MR. BROOKS:

in the jail because they are -- there must be -- there is the treatment for that if he suffer from any malnutrition, but they also have a medical department there, too.

Q And so a patient is going to be provided for in jail, correct?

A Right.

Q Would you agree it's important to know whether or not the person suffered from malnutrition or dehydration immediately preceding his arrest?

A Yes.

Q Now, have you ever made an attempt to speak to people from the jail to determine whether or not a patient who you deemed a danger to himself because of an inability to meet needs was suffering from malnutrition or dehydration at the time of arrest?

A Yeah. What's the process right now is that when the patient come from the jail, usually we have a medical report there and same time we have two psychiatrists' report there.

Q When you say two psychiatric reports, you're talking about competence, right?

A Except the clinical team. We have team members. If anybody has information, sometime I don't have, if they have some information, then we talk about it.

Q Would you agree, Doctor, that the information the clinical team has is about a patient's clinical condition?

A Right.

Q I'm not concerned about the patient's clinical condition. I'm concerned about --- (interrupted).

A Administration you're talking about?

Q Yes, not relating to the clinical presentation of a particular patient.

A Okay.

Q But what is required in terms of a level of certainty prior to certifying the patient for involuntary hospitalization.

A We, again, I'm telling you what we do. We collect information from the clinical team and information from the community, information from the emergency room or from the jail and on that ground and after talking to the patient, we make a decision

whether the patient -- as a psychiatrist I make a decision in the end whether patient meets criteria to admit him as a voluntary patient or commit on two PC.

Q Right, whether or not a patient meets the criteria, correct?

A Patient should meet criteria.

Q You have to determine whether or not the patient meets the criteria?

A Yes, in order make two PC or voluntary, right.

Q Right, and would you agree further that a determination of whether or not a patient meets the criteria requires a determination of the likelihood of a person causing harm to self or others?

A Yes.

Q And would you agree further that there may be a 1 percent chance that the person will cause harm and a 99 percent chance --- (interrupted).

A That's correct.

Q Has anybody ever spoken to you --- (interrupted).

A We talk -- you are asking the same question again and again.

Q That's because you didn't answer the question.

A No, actually, with the clinical team, they talk about it, but I'm not talking about -- beside clinical team, I don't know anything about it. Clinical team, I'm talking about psychologist, social worker, and my team, we work with the patient.

Q Okay. What do they say the level of certainty must be?

A No. We collect the information and whatever they have, they talk to me, and then I make a decision at the end.

Q And what is the level of certainty that must exist in your mind?

A At that time -- we make a decision at the time.

Q That's not my question.

A Yeah.

Q My question to you is you make a decision, right?

A Right, we make decision whether patient can

be admitted here as a voluntary status or involuntary status.

Q I'm only talking about involuntary now, all right?

A Okay.

Q What is the level of certainty that must exist in your mind for you to commit someone? Is it 1 percent, 99 percent 2 percent, 98 percent, 10 percent, 90 percent? What's the level of certainty?

BY MR. PEEPLES:

Objection.

BY THE WITNESS:

A I cannot answer that question.

BY MR. BROOKS:

Q Why not?

A Because I don't know the exact number.

Q Has anyone ever spoken to you about the level of certainty that's required for you to commit someone?

A No.

Q You have complete discretion to decide?

A We make a clinical decision.

Q Do you have complete discretion in your mind

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(Whereupon, the above-referred-to Certificate of Examining Physician for Ronald Bilyou was marked as Plaintiff's Exhibit 1 for Identification, as of this date, by the reporter.)

Q Here you go, Doctor. I'm going to ask you to read that, please. Is that your signature?

A Yes, this is my signature.

Q Can I ask you what you wrote, please?

A Say again.

Q Can I ask you what you wrote?

A Yeah. It's a 40 years old white man. He was referred from the Dutchess County Jail. He was arrested for harassment charges, said that he was in HRPC two years ago and currently he is psychotic and he denies suicidal ideation, homicidal ideation and needs hospitalization. He -- one second. He needs hospitalization. He need psychological testing for diagnosis and rule out organicity.

Q Now, Doctor, did you find that this patient,

but what happened by looking at history and what we check, and on that ground we made him involuntary at the time.

Q Well, do you believe that he posed a danger to himself or others or both?

A By looking at his history he made the threat to the neighbors and also he been to jail before, he was on probation. Also, he -- I think he has a substance abuse problem, too.

Q What is the reason for this conclusion?

A Again, I didn't write anything here, but before we make this conclusion we check everything.

Q What, are you guessing now?

A No, I'm not guessing.

BY MR. PEEPLES:

Objection to form.

BY THE WITNESS:

A I'm not guessing.

BY MR. BROOKS:

Q Okay. So, where does it say he has a substance abuse problem?

A Okay. Here the patient has a history of poly substance abuse, mainly cocaine and

alcohol.

BY MR. PEEPLES:

The witness is referring to exhibit 2, page HR05095. That's the Bates number.

BY MR. BROOKS:

Q Now, if he had a substance abuse problem, would that increase the risk of him causing harm to himself or others?

A Under the influence of drug or alcohol it's possible.

Q Is there any reason why you didn't note it on the form here, on this certification form?

A I did not write that.

Q I'm asking is there a reason why you didn't?

A Usually we don't write on the paper like that. At that time we just -- we don't write everything.

Q But you write the important stuff, do you not?

A We wrote the paper the way he came from the jail that we wrote that.

Q What do you mean the way he came from the jail?

A Why he was in jail and what charges he was there, and also I think we wrote that why he was going to do the psychological testing to rule out any organicity.

Q Now, Doctor, does this certification say you find based on the reasons set forth below that this person is dangerous?

BY MR. PEEPLES:

Objection to form.

BY MR. BROOKS:

Q I call your attention to number three and number four.

A But I did not document in this paper, but we looked in the history before we come to this conclusion.

Q And my question to you is why didn't you document it?

A At that time -- I don't know. That's the way we always write that, because we check history. We don't document everything in the chart -- in the paper.

Q How do you decide what to document and not to document?

A There is not any criteria what to document

and what to not to document, but that's the way we write that usually at that time.

Q When you say that's the way, what is the way?

A That's the way I wrote in the paper. I did not document everything in the chart, in this piece of paper, but we went through the history, physical, whatever was reason for admission, what happened in the past, and we looked at everything, but I did not document in this piece of paper.

Q Now, Doctor, you would agree that if he suffered from substance abuse, that would be a very important factor in assessing his dangerousness, correct?

A At the time, right, yeah.

Q And what were the other reasons why you believed he was dangerous?

A He was making threat to the neighbors and he was on probation, too, and I'm not sure if CPS was involved.

Q Now, is there any reason why you did not note on the certification that he was making threats to others?

A There's no real reason, but we don't -- I didn't document it. There's no specific reason for that, but we consider everything before we write this.

Q I'll tell you what, Doctor, could it have been that you were not aware that he was threatening at the time you completed this document?

A No, I was aware that he was making threat. We have to look everything what happened in the past, and that's the only ground we use that.

Q Doctor, are you aware that Exhibit 2 was completed the day after you completed Exhibit 1?

A Yes.

Q So, you would agree, Doctor, that Exhibit 2 was not in the chart when you completed your certification?

BY MR. PEEPLES:

Objection to the form.

BY THE WITNESS:

A No, old discharge summary. This is the psych evaluation part 2, but the old

discharge summary was available.

BY MR. BROOKS:

Q What did the old discharge summary say?

A I don't have right now copy of the old discharge summary here what they say.

Q Then how do you know the old discharge summary had the --- (interrupted).

A Because he was at Hudson River in the past.

Q Yes? Is it fair to say that the old discharge summary indicated that he threatened someone that resulted in him being put in jail?

BY MR. PEEPLES:

Objection to form.

BY THE WITNESS:

A I don't know.

BY MR. BROOKS:

Q Now, Doctor, again, in what way did you believe Mr. Bilyou posed a danger?

A Again, what I just told you before, we check his records --- (interrupted).

Q No, not the reasons. In what way? Was he a danger to others because of assaultive behavior? Was he a danger to himself

because of suicide? Could he not meet his basic needs? In what way did you conclude he was dangerous?

BY MR. PEEPLES:

Objection; asked and answered.

BY THE WITNESS:

A Because I mentioned before that what -- he made the threat to the neighbor, neighbor called the police, and that was one of the threat. Same day he was on probation and also he has a substance abuse history.

BY MR. BROOKS:

Move to strike as not responsive.

Q Doctor, we went through a number of different ways a person may be dangerous.

A Right.

Q In what way -- and what of those different categories of danger, such as danger to self because of inability to meet needs or a danger to others because of assaultive behavior, was this person dangerous?

A He was threatening to the neighbors. That was only thing I had.

Q So you're concluding he was a danger to

document everything here.

BY MR. BROOKS:

Q All right. Where did you get the information that he threatened someone?

A This was in the chart.

Q I'm sorry?

A In the chart. And also from -- it must be in the screening/admission note. This is a part two. Screening/admission note is different. This is a part two.

BY MR. BROOKS:

Okay. Let's go off the record.

(Whereupon, there was a brief recess taken.)

BY MR. BROOKS:

Can I ask you to mark this.

(Whereupon, the above-referred-to Certificate of Examining Physician for Mercedes Fuso was marked as Plaintiff's Exhibit 3 for Identification, as of this date, by the reporter.)

Q I'm going to ask you, is this your signature and handwriting, Doctor?

A Yes.

Q Please read.

A 86 years old, white female, widow, who was admitted here on August 10, 2005 on CPS 730.40, Final Order Observation with dismissal of the charges. She was charged with criminal mischief in the second degree. She stated that my neighbors did -- I can't get that word before -- did get before. She was reported by the neighbor that she was throwing feces on their door and on the car. She denies past psychiatric help and treatment. She had few arrests before and she needs further inpatient care to rule out any dementia.

Q Do you believe this person posed a danger to herself or to others?

A Yes, but I have to -- I need the chart. I don't remember what was reason for. I'm not sure. She was arrested in Dutchess County Jail for throwing the feces on the

KANTILAL SHAH, M.D.

Certificate of Examining Physician for Debbie Harrington was marked as Plaintiff's Exhibit 5 for Identification, as of this date, by the reporter.)

Q Is this your signature, Doctor?

A Yes.

Q Can you read what you wrote?

A Yeah. This is a 52 years old white female referred from the Dutchess County Jail. She was arrested for possessing of the cocaine. The patient has a long history of psych illness. Patient has history of overdose of the pills. Patient has a history of poor compliance with medication and aftercare follow-up. The patient has no insight to her illness and her judgment is poor and needs further stabilization.

Q Did you believe this patient posed a danger to herself or others?

A If you give me the summary, I can -- I don't remember what was. I don't have a copy of that, of the information that I had.

BY MR. BROOKS:

KANTILAL SHAH, M.D.

Mark this please, Plaintiff's Exhibit 6.

(Whereupon, the above-referred-to Screening/Admission Note and Psychiatric Evaluation for Debbie Harrington was marked as Plaintiff's Exhibit 6 for Identification, as of this date, by the reporter.)

Q Does this help refresh your recollection, Doctor?

A Yeah. Now, how we came to conclusion you wanted to know about she's dangerous.

Q No. First I want to know in what way was this person dangerous, if any?

A Yeah. Well, by looking at her history --- (interrupted).

Q No. Doctor --- (interrupted).

A Why --- (interrupted).

Q In what way? Not what did you rely upon that lead you to believe she was dangerous. In what way was she a danger to herself or a danger to others?

A Dangerous to herself, because she took many

overdose in the past and also present admission she took overdose of the cocaine.

Q So was she a danger to herself because of a threat of suicide or because she was going to take drugs and have disorganized thinking?

A By looking at her history she has long history of taking overdose. Also, whenever she's in manic phase, she has history of not taking the medication, and aftercare follow-up, plus she has a substance abuse history. By looking all the factors at the time and we make conclusion at the time.

Q Doctor, a while ago you said there were about five ways that a person is dangerous, correct?

A Yes.

Q Which of these five ways was she dangerous?

A In her case, like, she has a history of overdose, she has noncompliance.

Q Noncompliance is not a way someone is dangerous.

BY MR. BROOKS:

Mike --- (interrupted).

A She becomes manic and doesn't take and when somebody's manic, their psychotic symptoms reappear.

Q That's not my question, Doctor.

A Now, you're just telling me how I came to conclusion. I looked at --- (interrupted).

Q No, that's not what I'm asking you. I'll get to that.

BY MR. BROOKS:

Can you help out, Mike? You want to try and help out or are you basically saying you're on your own?

BY MR. PEEPLES:

You want me to ask the question?

BY MR. BROOKS:

I'd like you to explain, try and -- yes, explain that we spoke about the different ways to be dangerous. That's what I'm looking for before we go any farther.

BY MR. PEEPLES:

Dr. Shah, I think Mr. Brooks is asking you whether you recall or whether you found that this individual is dangerous to herself because she might injure herself or was she

dangerous because she might commit suicide or was she dangerous to others or was she dangerous for some other reason or for some combination.

BY THE WITNESS:

More or less dangerous to herself.

BY MR. BROOKS:

Q Because of a threat of suicide or because of an attempt to take drugs?

A Both, suicide and drugs.

Q Was she a danger to others?

A Not at that time.

Q Did she meet her essential needs of food, clothing, and shelter?

A That I don't recall right now, whether what she did at the time, but when we check the history and everything, she had --- (interrupted).

Q Okay. Hang on.

A Yeah.

Q Did you find at the time you evaluated her that she had a history of suicide attempts?

A Yes.

Q How come you didn't write it down?

A I wrote there's a history of the overdose of the pills.

Q Okay. Do you recall how many times she attempted to overdose on pills?

A I don't know the exact number.

Q Did you ask her whether or not she intended to overdose at the present time?

A I did ask her at the time. She denied, but what, see, happens in the past she denies.

Q What did she deny?

A She's not going to do it.

Q Okay. So, did she deny that she did it in the past?

A No.

Q She admitted it?

A She admitted she did it in the past.

Q Would you agree that the fact that she did not intend to act on any suicide or -- question withdrawn.

Did the patient deny that she intended to act on suicidal thoughts?

A When I examined the patient, when asked whether you are going to harm yourself or take an overdose, patient denies.

Q Does her denial lower the risk of her causing harm to herself?

A The patient denied, but by what -- patient denies, but by looking her history and by looking her other history of substance abuse, poor compliance, psych illness, manic disorder, bipolar; combining all the factors, she became dangerous.

Q Any other reasons why you believe she posed a danger to herself?

A I think I saw some family history. I'm not sure I saw someplace or not. Only thing I consider about that that she has no support system at the time. She was on the -- just about homeless.

Q Any reason why you didn't note the lack of support system?

A Again, I didn't write. There's no other reason, but I did not write.

Q No reason being you weren't thinking about it?

A At the time we collect information, but I did not write in this piece of paper.

Q That much we know. I'm trying to figure out

(Plaintiffs' Ex. 7 - CERTIFICATE OF EXAMINING PHYSICIAN FOR SHARON DEYO CARNEY marked for identification.)

KANTILAL SHAH, M.D.,

Having been first duly sworn by Karen M. Flemmig, a Notary Public of the State of New York, was examined and testified as follows:

* * * * * *

EXAMINATION BY MR. BROOKS:

Q. Doctor, have you read this?

A. Yes. As much as I can. Only this line, I don't know what is here, at the bottom.

Q. I'm showing you the Certificate of Examining Physician for a patient named Sharon Carney; correct?

A. That's correct.

Q. Is that your signature?

A. That's my signature.

Q. Could you please read what you wrote?

A. "Thirty-eight year old black female discharged from the Dutchess County Jail. She has a history of mental illness for a while. She remains suspicious, paranoid, and disorganized. She has no insight into her illness." Then I don't know what the word is after that. This one at the bottom, I don't know what it is.

It didn't come clear. "Unable to carry on logical conversation with her. She needs further stabilization."

Q. Now, Doctor, did you examine Sharon Carney?

A. Yes.

Q. After examining Ms. Carney, did you conclude that she posed a danger to herself or others?

A. Yes. By looking, I don't have the records with me at this time, but before we do that, we have to have all the admissions screening and what information I have from Dutchess County Jail back to psychiatrist. The if patient was previously here, we get all discharge summary. The patient was here before, then we need all the records, the last discharge summary.

Q. Now, can you recall whether or not you concluded that she posed a danger to herself or to others?

A. I cannot recall. If you have psych assessment or whatever. I cannot recall. I don't know until I have the records.

Q. Doctor, what is the clinical significance, if any, that she was referred to the Dutchess County Jail?

A. It was dangers she exposed in the community.

Q. Excuse me?

Q. How does the fact that she was paranoid indicate what her suspicious thoughts were?

A. If somebody was paranoid about particular things, sometimes people do react to their delusions.

Q. I'm sorry?

A. Sometimes the patient reacts to the particular delusion.

Q. And sometimes a person does not act to a particular delusion?

A. That's correct.

Q. Didn't you concede at the earlier portion of this deposition a person who does not react on delusions is far less of a threat than a person who does have an intent to act on a delusion?

MR. PEEPLES: Objection to form.

A. I don't know.

Q. You don't remember?

A. No.

Q. I'll try to ask it again. Would you concede, Doctor, that a person who intends to act on a delusion is more dangerous than a person who does not intend to act on a delusion?

A. That's correct.

Q. Would you agree further that a person who

intends to act on paranoia is more dangerous than a person who does not intend to act on paranoia?

A. Yes.

Q. Would you agree further, Doctor, that not all paranoid people are dangerous?

A. Not all paranoid people, no.

Q. I'm sorry?

A. Not all paranoid people are dangerous, no.

Q. So you agree with my statement?

A. Yes.

Q. So if not all paranoid people are dangerous, how does the fact that you noted she was paranoid indicate what she was thinking about when you noted she was suspicious?

A. Again, I don't remember at that time what was in my conversation.

Q. Would you concede, Doctor, that when assessing someone for dangerousness, that because not all paranoid people are dangerous, it is more important to know whether or not a person intends to act on paranoia than it is to know that the person is paranoid?

MR. PEEPLES: Objection. Asked and answered.

A. Can you just repeat it?

Q. Sure. When assessing someone for dangerousness, which is more important to know; one, whether or not the person intends to act on paranoia, or, two, that the person is paranoid in and of itself?

MR. PEEPLES: Objection. Asked and answered.

A. Usually who has a history of reacting to paranoia in the past to delusions tend to more react again.

MR. BROOKS: I move to strike as not responsive.

Q. We're not talking about history of reacting. I'll get to that. When assessing someone for dangerousness, which is a more important piece of information to note; one, that the person is paranoid, or, two, that the person has paranoia and intends to acts on the paranoia?

MR. PEEPLES: Objection to form.

A. It's important.

Q. Which is more important?

MR. PEEPLES: Objection.

A. Are you talking about both, suspicion and paranoia?

Q. No.

A. Paranoid toward what?

Q. Let me try it again. When assessing a patient for dangerousness, which is a more important piece of information from a clinical perspective; one, that the person is paranoid, or, two, that the person is paranoid and intends to act on the paranoia?

MR. PEEPLES: Objection.

A. Intends to act on paranoia is more important.

Q. Thank you.

A. Would you agree further that if the person did not intend to act on the paranoia, that would be more probative of dangerousness than simply knowing the person was paranoid?

MR. PEEPLES: Objection to form.

A. I don't know what you mean. If somebody has --

MR. PEEPLES: Do you understand what probative means?

THE WITNESS: No.

Q. Doctor, you're trying to determine whether or not someone is dangerous. Okay?

A. Yes.

Q. Which is more important; the fact that the person is paranoid, or that the person does not intend

to act on any paranoia that the person has?

MR. PEEPLES: Objection. Asked and answered.

MR. BROOKS: Not a chance.

MR. PEEPLES: That's the same question.

Q. You're on, Doctor.

A. Any paranoid patient, usually, if they react in the past, possibly they react again to their delusion.

Q. Doctor, I have to tell you, that's not even close to answering my question. My question involved an intent to act, not a history of acting. I know history of acting is important. I'll get to that. But please stick to my question.

A. I don't know the answer.

Q. I'm sorry?

A. I don't know the answer.

Q. When you're assessing someone for danger, which is a more important piece of information; one, that the person has paranoia, or, two, that the person has paranoia but does not intend to act on any paranoia?

A. They both are important.

MR. PEEPLES: Objection.

Q. Which is more important?

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MR. PEEPLES: Objection to form.

Q. Is that what you're saying?

A. We did ask, but we did not write down here. We did ask about this thing.

MR. BROOKS: We'll move on.

MR. PEEPLES: Might as well. We spent an hour and a half on that one.

MR. BROOKS: Mark this, please.

(Plaintiffs' Ex. 8 - CERTIFICATE OF EXAMINING PHYSICIAN FOR FABIAN GITTENS marked for identification.)

BY MR. BROOKS:

Q. Doctor, is this your signature on that page?

A. Yes.

Q. Please read what you wrote?

A. "Twenty-nine year old white man transferred from the Dutchess County Jail. He was arrested for sexual harassment. He attempted to put his hands -- the female in the store and attempted to take her into the bathroom. Patient is delusional and paranoid. He was in Hudson River Psych Center outpatient in 1997. Patient has a long history of psychiatric illness with poor compliance with medications and after care follow up. Patient needs further stabilization."

are stopping the deposition of Dr. Shaw because Dr. Shah has stated that he has to go someplace.

THE WITNESS: That was last time.

MR. BROOKS: Can we continue?

MR. PEEPLES: We'll keep going then.

MR. BROOKS: We'll mark this as Plaintiffs' 10.

(Plaintiffs' Ex. 10 - CERTIFICATE OF EXAMINING PHYSICIAN FOR CHRIS DUSAULT marked for identification.)

A. I examined the patient on January 26, 2001. "This is a forty-year-old white male. He was referred from Dutchess County Jail. He was charged with stalking with the fourth degree. Patient has long history of psych illness. He was last discharged from Hudson River Psych Center on August 25th, 2000, to Edgewood Community Residence. He was in the mall with his father and he met one of his old girlfriends. Then attempted to talk to her. She has an order of protection and she called the police and was arrested. Patient has long history of psych illness, hospitalization. He is suspicious and some evidence of thought blocking. Patient has no insight into his illness and needs further care."

Q. Doctor, this is your signature; right?

thought blocking, he was suspicious, and was not taking his medication served for your basis that he posed a danger to others?

MR. PEEPLES: Objection to form.

A. I'm not saying that. I don't have the records in front of me right now. I don't remember why I came to that conclusion.

Q. All right.

MR. BROOKS: Mark this as Exhibit 11.

(Plaintiffs' Ex. 11 - CERTIFICATE OF EXAMINING PHYSICIAN FOR ALLEN KURT marked for identification.)

BY MR. BROOKS:

Q. Is this your signature, Doctor?

A. Yes.

Q. Please read what you wrote.

A. Okay. "Thirty-six year old white male. He was referred from Westchester County Jail. He remains disorganized, religiously preoccupied, and delusional. His personal hygiene is poor. He has been refusing his medication. Patient is uncooperative, unable to get any information from him. He needs further stabilization."

Q. Doctor, do you believe that Mr. Allen posed a danger to others?

BY MR. BROUTMAN:

Would you please mark this before we begin.

(Whereupon, the above-referred-to Certificate of Examining Physician for Michael Karkota was marked as Plaintiff's Exhibit 12 for Identification, as of this date, by the reporter.)

KANTILAL SHAH, M.D.,

produced on behalf of the Defendant herein, having been previously sworn, upon being examined, testified as follows:

*****

EXAMINATION BY MR. BROUTMAN:

Q Dr. Shah, just take a look at what's been marked Plaintiff's Exhibit 12 and did you complete this commitment certificate, Doctor?

A Yes, it is my signature there. Just one

second.

Q Sure. If you can just read what you wrote into the record.

A Yeah. This is a 48 years old white male. He was admitted from Dutchess County Jail. He reported that he was living in Hedgewood, H-e-d-g-e-w-o-o-d, Home and he was arrested for assault charges.

He was sent to the Central New York Psych Center and then returned back to the Dutchess County Jail. He has been seeing psychiatrist for many years. Patient reports that he goes to Montrose VA Hospital for follow-up, is still somewhat suspicious and paranoid and he needs further stabilization.

Q Doctor, did you find that Mr. Karkota presented a danger to himself, a danger to others, or both?

A Right now I don't have the records, but usually when we complete the certificate, we check the informations, what we had from the CPL 730.40 or from Dutchess County Jail, and also we check all the records and

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Q Now, with regard to the assault that got Mr. Karkota arrested, did you find out any information about the circumstances surrounding that assault?

A At what happened at Hedgewood?

Q Yes.

A Exactly, I don't know the information. Yes, I see from the police report actually what happened.

Q And would you have had access to the police report at the time that you completed the commitment certificate?

A Only we have the report of the two psychiatrists who examine the patient at the jail. That report was available.

BY MR. BROUTMAN:

Would you mark this please, Plaintiff's Exhibit 14.

(Whereupon, the above-referred-to Certificate of Examining Physician for Mark Taylor was marked as Plaintiff's Exhibit 14 for Identification, as of this date, by the reporter.)

Q Here you go, Dr. Shah. Is this your handwriting?

A Yes, it's mine.

Q On Plaintiff's Exhibit 14?

A Yes.

Q Can you read what you wrote into the record, please?

A One line -- I can try to as much I can. This is a 24 years old white man. He was referred from the Ulster County Jail on 730.40 from the Final Order of Observation. He was arrested from possession of the weapon, 4th degree. He has long history of psychotic illness and hospitalization with poor compliance with the medication.

He was interviewed today and he's still hostiles and he denies any thought to hurt others. His behavior still is unpredictable and he needs further stabilization.

Q Now, based solely on what you have written in Plaintiff's Exhibit 14, can you tell me if you concluded that Mr. Taylor was a

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Certificate of Examining Physician for James Winters was marked as Plaintiff's Exhibit 16 for Identification, as of this date, by the reporter.)

Q Here you go, Doctor. Is this your handwriting on Plaintiff's Exhibit 16?

A Yes, this is my handwriting.

Q And when you're done reading it, if you could just read what you wrote into the record.

A Patient was transferred from the Dutchess County Jail on June 9, 2003. He has a long history of substance abuse and emotional problem with the poor compliance with the medication and treatment recommendation. He has no insight into his illness, judgment is poor, and he needs further stabilization. Patient stated that he was hearing voices, but now he takes the medication so he feels good and does not hear voices.

Q Now, based upon what you have written in Plaintiff's Exhibit 16, can you tell me if you concluded that Mr. Winters posed a